STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P. O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax (517) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 2013-17065 CMH
Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held on [redacted]. [redacted], Case Manager, Consumer Services Inc., represented the Appellant. [redacted], mother, appeared as a witness for the Appellant.

[redacted], Hearing Coordinator, appeared on behalf of [redacted] County Community Mental Health (CMH or the Department). [redacted], Care Coordinator, Utilization Management, appeared as a witness for the Department.

ISSUE

Did the CMH properly determine the Appellant's respite hours?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary who has been receiving services through [redacted] County Community Mental Health (CMH) of targeted case management, medication reviews, therapy, and respite. (Hearing Coordinator Testimony)

2. The CMH is under contract with the Department of Community Health (MDCH) to provide Medicaid covered services to people who reside in the applicable service area.

3. The Appellant is a [redacted] year old Medicaid beneficiary whose date of birth is [redacted]. The Appellant has severe mood swings and irritability. The Appellant's mother must provide constant re-direction to do the right thing and keep the Appellant from fighting. (Exhibit 1, page 3)

4. The Appellant lives in the family home. The Appellant's mother is his primary caregiver. The Appellant's mother is disabled and has diagnoses of rheumatoid arthritis, fibromyalgia, scoliosis of the back, and bipolar. The Appellant's father works outside the home. (Exhibit 1, pages 1-3; Mother Testimony)

5. The Appellant attends school, 8 hours per day. (Exhibit 1, page 3)

6. On [redacted], a Respite Assessment was completed and 38 hours per month of respite were requested. (Exhibit 1, pages 1-4)

7. As a result of the Respite Assessment, the Appellant was approved for 19 hours of respite per month. (Exhibit 1, pages 1-5)

8. On [redacted], the CMH sent an Adequate Action Notice to the Appellant's mother notifying her that the request for 38 respite hours per month was denied, but 19 respite hours per month were approved. The notice included rights to a Medicaid fair hearing. (Exhibit 1, pages 5-7)

9. The Michigan Administrative Hearing System received Appellant's request for hearing on [redacted]. (Exhibit 2)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be

> administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver. The CMH contracts with the Michigan Department of Community Health to provide services under the waiver pursuant to its contract obligations with the Department.

Medicaid beneficiaries are entitled to medically necessary Medicaid covered services for which they are eligible. Services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See 42 CFR 440.230.*

The *Medicaid Provider Manual, Mental Health/Substance Abuse,* section articulates Medicaid policy for Michigan. Its states with regard respite:

> **17.3.J. RESPITE CARE SERVICES**
>
> Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In

> those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.
>
> *MPM, Mental Health and Substance Abuse Section, October 1, 2012, Pages 123-124*

The Medicaid Provider Manual also explicitly states that B3 supports and services, the category of services for which Appellant is eligible, is not intended to meet every minute of need, in particular when parents of children without disabilities would be expected to be providing care:

> Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. <u>It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities.</u> MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service. (Emphasis added).
>
> *MPM, Mental Health and Substance Abuse Section, October 1, 2012, Page 111*

The CMH is mandated by federal regulation to perform an assessment for the Appellant to determine what Medicaid services are medically necessary and determine the amount or level of the Medicaid medically necessary services that are needed to reasonably achieve his goals.

The Care Coordinator reviewed Appellant's [redacted] Respite Assessment and explained the areas that allowed for the authorization of respite hours. The Appellant was awarded 2 respite hours because the Appellant's primary care giver has a condition that interferes with the provision of care, 1 respite hour because the Appellant is verbally abusive daily, 3 respite hours because the Appellant is physically abusive to others daily, 2 respite hours because the Appellant has temper tantrums daily, 2 respite hours because the Appellant wanders daily, 2 respite hours because the Appellant requires reminding with oral care, 2 respite hours because the Appellant requires reminding with bathing, and 2 respite hours because the Appellant requires reminding with dressing. The Care Coordinator testified that the Appellant was also awarded 3 respite hours because the Appellant requires extensive prompting and encouragement. In total, the Appellant was authorized 19 respite hours per month. The Care Coordinator noted that no respite hours were authorized related to the assistance the Appellant receives with medication administration because he is under age 18, therefore, this is considered a parental responsibility. (Exhibit 1, pages 1-4; Care Coordinator Testimony)

The Care Coordinator explained that Appellant's overall number of respite hours may be lower than it had been previously because the respite assessment scoring tool changed in [redacted]. Under the prior scoring tool, individuals were granted 20 respite hours per month from the start; then additional hours were added depending on specific needs. Under the current scoring tool, individuals are no longer granted 20 respite hours up front, but those 20 hours have been redistributed throughout the scoring tool, and are available based on individual need. The Care Coordinator explained that Genesee County realized that it was an outlier with regard to granting 20 respite hours up front and that it changed its policy to come in-line with other counties in the State. The Care Coordinator also indicated that the new scoring tool is now much more objective, needs based, and all authorizations for services are based on documentation. The Care Coordinator indicated that it is possible to obtain the maximum of 96 hours of respite hours per month using the scoring tool. The Care Coordinator also testified that the person who conducts the interview for the assessment is not privy to the scoring system; hence there is no risk that the interviewer could manipulate the answers to affect the score. The Care Coordinator explained that respite hours are not clinical treatment services. Finally, The Care Coordinator testified that, in her professional opinion, the 19 respite hours approved per month accurately reflects the needs of the Appellant.

The Appellant's mother testified that she is trying to get more hours for the Appellant. The Appellant has very bad behavior and anger issues. Working with the respite worker, who has been with him a number of years, helps the Appellant. The Appellant is happy to go places with the respite worker and even works better on homework with

her than he does with his mother. The reduced hours make the Appellant more aggressive as he feels like no one cares. The Appellant is getting to where he thinks he can put his hands on his mother. About two weeks before the [redacted] hearing date the Appellant put his hands around his mother's neck. The Appellant's mother also stated that the Appellant was involved with some friends in a property destruction incident last year. (Mother Testimony)

The testimony indicated that another type of service, Community Living Supports, has not been requested for the Appellant. (Case Manager Testimony)

The evidence supports the CMH's determination to authorize only 19 respite hours per month instead of the requested 38 hours. The Appellant bears the burden of proving by a preponderance of the evidence that the approved 19 hours of respite per month was inadequate to meet the medically necessary need for respite. The Appellant did not meet this burden. The CMH adequately explained what led to a decrease in Appellant's respite hours and how it calculated the number of respite hours that are medically necessary. Under the Medicaid Provider Manual policy, B3 supports and services are not intended to meet all of an individual's needs and it is reasonable to expect parents of children with disabilities to provide the same level of care they would provide to their children without disabilities. Further, respite hours are intended to be provided on intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times. Respite hours are not intended to be authorized as an ongoing clinical treatment service for the beneficiary.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that 19 respite hours per month are appropriate.

IT IS THEREFORE ORDERED that:

The CMH decision is AFFIRMED.

Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 4/26/2013

***** NOTICE *****

The Michigan Administrative Hearing System may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The Michigan Administrative Hearing System will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.